DMH POLICY

Antipsychotic Medications (Rogers Decision)	**Policy #: 83-50** **Date Issued:** December 16, 1983 **Effective Date:** December 16, 1983
Approval by Commissioner **Signed by:** James J. Callahan, Jr., Ph.D.	**Date:** December 16, 1983

TO: James J. Callahan, Jr., Ph.D., Commissioner

FROM: Richard Ames, General Counsel

RE: Rogers – Implications for Administration of Antipsychotic Medication

DATE: December 16, 1983

On November, 29, 1983, the Massachusetts Supreme Judicial Court issued its decision in the case of Rogers v. Commissioner of Mental Health. In this memorandum, I will attempt to set forth the major implications of the decision for the administration of antipsychotic medications in DMH facilities and programs. Pending development of new DMH policies and regulations responsive to this decision, this memorandum may serve as a guideline for use in the field.

I. Overview

The decision has major implications for all situations in which antipsychotic medications are prescribed or administered. Having identified "treatment with antipsychotic medications" as "extraordinary medical treatment", the decision is not limited to situations where individuals are refusing such treatment. New requirements are established for informing all patients of the risks and benefits of proposed or ongoing courses of medication treatment. Judicial review and approval is required not only to overcome patient refusals but also, in many situations, to confirm patient and/or guardian acceptances of treatment with medications. Chemical restraint, as defined by statute and in Department regulations, remains as a narrow exception to this rule. In addition, emergency treatment with medications of certain patients over their objections may be initiated to prevent the "immediate, substantial, and irreversible deterioration of a serious mental illness," but may not be continued over a patient's objection without judicial involvement.

As a very rough estimate, close to 1,000 cases may need to be brought to court from the mental retardation facilities; at least an equally large caseload may develop at the inpatient mental health facilities; there may be numerous other cases involving individuals who are currently in community programs. Existing legal resources are not sufficient to manage immediately so many new cases; clinical time required for competency evaluations, medical certificates, case preparation and courtroom appearances will be a new and very difficult burden for our existing clinical staff.

II. Definition of Antipsychotic Medications

Although there may be other implications that will need to be addressed at a later time, the immediate import of the decision concerns the administration of antipsychotic medications: "Because the parties focus on antipsychotic drugs, our answers concerning medication are limited to antipsychotic drugs." (See Footnote 3). The decision refers to Footnote 1 of the opinion of the U.S. Circuit Court of Appeals in Rogers v. Okin, 634 F.2d 650 (1st Cir. 1980) for the following definition of this term:

> "We use the term "antipsychotic drugs" to refer to medications such as Thorazine, Mellaril, Prolixis (sic) and Haldol that are used in treating psychoses, particularly schizophrenia. The district court used this term interchangeably with the apparently broader term "psychotropic drugs", which may include anti-depressants and lithium, and which as far as the record shows do not have as substantial a potential for serious side effects as do the antipsychotics. Both the parties and the district court have throughout this litigation focused exclusively on the anti-psychotics….Accordingly, we interpret the district court's use of the term "psychotropic drugs" to mean antipsychotic drugs. The potentially harmful side effects of these drugs are set forth in detail in the record, and described in part in the district court opinion. Foremost among them is tardive dyskinesia, a painful, disfiguring, and sometimes disabling neurological affliction which all parties in this case concede might be caused by the use of antipsychotic drugs.

III. Continuity of Treatment

With respect to individuals who are refusing treatment with antipsychotic medication, the decision continues the pattern that was established by Judge Tauro's original decision in October, 1979. Treatment with antipsychotic medications for these patients must not be initiated or must be interrupted (absent an emergency) pending the outcome of an appropriate judicial process.

With respect to other patients, where there has been active or passive acceptance of medication and where there is now a new requirement for judicial review, the question arises as to whether the treatment should not be initiated or should be interrupted pending the outcome of the required judicial review. Thus, the decision appears to require informed consent and yet hundreds of the Department's clients are unable to give this consent, implying a need in each such case for judicial review. While every effort will be made to develop expedited procedures with the judiciary, there may be extensive delays before judicial review is initiated or completed. During this period, I strongly advise against any discontinuity in prescribed medical treatment. Where antipsychotic medications have been prescribed, where there is no indication of a refusal, and where best efforts are being made by Department staff to initiate the process of judicial review called for by Rogers, a failure to proceed with this treatment while awaiting judicially sanctioned consent might well violate an individual's legal rights to treatment.

Accordingly, while there must be assurance that all antipsychotic medication programs have been prescribed and are maintained in accordance with accepted medical practices, and that all patients within the limits of their capacity to understand are properly informed as to the risks and benefits of their medication program, the inevitable delays involved in obtaining judicial review where there is passive or active acceptance of the medication will be an insufficient reason by itself to interrupt or not initiate the treatment. In these circumstances, the legal hazards of proceeding without informed consent are in my opinion outweighed by the greater hazards of not proceeding with the prescribed psychiatric treatment.

IV. Informing Patients

The Court sets forth its expectations regarding the issue of informing patients as to medication treatment in a footnote as follows:

> "Patients must receive appropriate information on which to exercise the voluntary choice to accept or reject antipsychotic drugs on an informed consent basis. See Harnish v. Children's Hosp. Medical Center 387 Mass. 152 (1982); Saikewicz, supra at 730. 'Appropriate information may include the nature of the patient's condition, the nature and probability of risks involved, the benefits to be reasonably expected, the inability of the physician to predict results, if that is the situation, the irreversibility of the procedure, if that be the case, the likely result of no treatment, and the available alternatives, including their risks and benefits.' Harnish, supra at 156. Further, competent patients may, at any time, revoke their prior consent and refuse to continue with the treatment." (See Footnote 11)

This advice should be closely followed in all cases involving the administration of antipsychotic medication to Department clients. If an individual is clearly incapable of understanding the indicated information, this should be noted in the record and, in these circumstances, the information does not need to be provided to the individual.

V. Refusals of Antipsychotic Medication

A. Refusals in General. Absent the emergency circumstances described in paragraphs B and C below, a patient's refusal of antipsychotic medication may be overridden only by the decision of a judge. In fact, two sequential determinations are required of the judge for such a decision: first, that the patient is legally incompetent to make the treatment decision (a competency determination); second, that the patient, if competent, would consent to the medication (a substituted judgment determination). If a judge makes such a decision, he or she must further " 'authorize a treatment program which utilizes various specifically identified medications administered over a prolonged period of time. In such a case, the order should provide for periodic review to determine if the ward's condition and circumstances have substantially changed. Guardianship of Roe' "See Rogers p.22.

The Legal Office (see Paragraph VII below) will (within the limits of available resources) initiate petitions or complaints in cases where there is sufficient factual

foundation for a treating physician's belief that the patient's refusal should be overridden and that the standards described above for a judicial determination of incompetency and substituted judgment can be met. This procedure appears to be parallel to but more complex and time consuming than the process followed by the Department since October, 1979, for all non-emergency refusals of antipsychotic medication.

B. Chemical Restraint. If a patient refuses antipsychotic medication, the medication may be administered forcibly as restraint "only in emergency situations where there is the occurrence or serious threat of extreme violence, personal injury, or attempted suicide." 104 CMR 3.12(2). The Court underscores the restrictiveness of this language and concludes that chemical restraint may be used "only if a patient poses an imminent threat of harm to himself or others, and only if there is no less intrusive alternative to antipsychotic drugs." See Rogers pp. 27-28. In a footnote to this discussion of chemical restraint, the Court makes the following additional observation:

> "The defendants suggest that certain patients, as a symptom of their illness, will periodically threaten violence. Predictable crises are not within the definition of emergency….Therefore, in those cases, the consent of the patient for medication with antipsychotic drugs must be obtained in advance, while the patient is competent and calm…." (See Footnote 26)

The Court's advice should be closely followed in all such cases. I would add, however, that if a crisis does in fact develop where there is an imminent threat of serious harm, restraint (including chemical restraint, mechanical restraint or seclusion) may then be used to prevent the threatened harm. Additionally, if it appears that there has been a revocation of a prior consent, the revocation must be honored and the medication may proceed over objection only in an emergency or with judicial approval.

C. Emergency Treatment. Antipsychotic medication may "in rare circumstances" be administered for treatment purposes over the objection of a patient if (a) the treating physician determines that the medication is necessary to prevent the "immediate, substantial, and irreversible deterioration of a serious mental illness", and (b) the patient has either been adjudicated incompetent or is "one whom doctors, in the exercise of their professional judgment, believe to be incompetent." This "interim treatment" may be continued over the patient's objection only if appropriate judicial procedures (see below) are initiated.

VI. Acceptance of Antipsychotic Medication

A. Acceptance By Wards Or By Their Guardians. If an individual has been found legally incompetent and a guardian has been appointed, neither the acceptance or consent by the individual or by the guardian will be sufficient for indefinite continuation of a course of treatment with antipsychotic medications. The Court makes this point clear in

Footnote 14: "…because incompetent persons cannot meaningfully consent to medical treatment, a substituted judgment by a judge should be undertaken for the incompetent patient even if the patient accepts the medical treatment."

Accordingly, except where there has been a prior substituted judgment adjudication by a court, all such cases must be brought to the attention of the Legal Office (see Paragraph VII below) as soon as possible. Appropriate petitions or motions will be prepared as soon as possible in these cases to initiate the process of judicial review. In the interim, the advice set forth in parts III and IV of this memorandum should be noted.

B. Acceptance By An Individual Who Has Been Determined To Be Incompetent To Make Treatment Decisions At A Periodic Review. Under G.L. c.123, s.4, periodic reviews are required for all individuals in departmental facilities. The periodic review must include "an evaluation of the legal incompetency of the person and the necessity or advisability of having a guardian or conservator appointed or removed." This requirement is further amplified by DMH regulations at 104 CMR 3.11(5) for inpatient mental health facilities and 104 CMR 21.47(7) for mental retardation facilities. It is my understanding that there are many individuals in Department facilities who are not under guardianship but who have been found at a periodic review to be unable to make competent medical treatment decisions. Many of these individuals are currently receiving and accepting treatment with antipsychotic medications.

An individual in this situation remains legally competent: "We conclude that a mental patient has the right to make treatment decisions and does not lose that right until the patient is adjudicated incompetent by a judge through incompetence proceedings. See G.L. c.201, s.6. No other procedure is available for determining that a patient lacks the capacity to make treatment decisions." See Rogers, pp. 9,10. The periodic review determination, however, places in substantial doubt the actual 'capacity of the individual to "receive appropriate information on which to exercise the voluntary choice to accept or reject antipsychotic drugs on an informed consent basis" (my emphasis) (See Footnote 11, also quoted in paragraph III of this memorandum).

Under these circumstances, I believe the Department must now initiate a process of clinical and judicial review leading to a judicial determination of competency and substituted judgment. These cases should, therefore, be brought to the attention of the Legal Office. (See Paragraph VII below). Pending the initiation and conclusion of this process of judicial review, the course of treatment with antipsychotic medication may continue consistent with the discussion above in Paragraph III and IV of this memorandum.

Finally, with respect to periodic review determinations, it should be noted that the statute requires the legal competency evaluation to occur as part of a periodic review "at least upon admission, once during the first three months after admission, once during the second three months after admission and annually thereafter" G.L. c.123, s.4. It is essential that these evaluations occur on a timely basis (particularly when a clinician has

made an initial assessment that an individual is not capable of making informed medical care decisions), in order to provide a proper foundation for determining whether or not judicial review of antipsychotic treatment decisions will be necessary.

C. Acceptance By All Other Individuals.

Absent an adjudication of legal incompetence or a periodic review determination of incompetence, an individual's acceptance of antipsychotic medications will provide a sufficient basis for continued treatment with such medications. The requirements summarized in Paragraph IV above for informing such individuals must, of course, be observed.

VII. Procedures

The Legal Office will be discussing the legal processes required by this decision with the Attorney General's Office, representatives of the Judiciary, legal advocacy groups and others. The purpose of these discussions will be to establish a consensual framework within which the issues identified in this memorandum may be resolved in a thoughtful and ordered way. In the interim, cases which are brought to the Legal Office consistent with the advice contained in this memorandum should be initially presented on the attached form, Attachment A. The cases should be approved by the facility head or designee before being brought to the Legal Office. Attachment B lists the lawyers who have been assigned to each of the Department's facilities. Cases should be presented to the appropriate lawyer. Additional guidelines relative to less intrusive procedures, consent, competency, substituted judgment, guardianship and judicial procedures will be made available through these lawyers or through the facility heads.

VIII. Legislation

The decision is based on interpretations of common law and state statutes: "Because the answers to the certified questions are controlled by Massachusetts statutory and common law, we do not discuss the issues under the State Constitution." (See Footnote 7). While this state law foundation most probably will negate any further appeal to the federal courts, legislative proposals may be considered to modify the substantive or procedural requirements of the decision. The Legal Office will be reviewing the need for legislative change as we proceed with a good faith effort to implement the decision. Any proposals for such legislative change from the field should be forwarded directly to my attention.

DECISION CHART*

ANTIPSYCHOTIC MEDICATION TREATMENT FOR MENTALLY ILL
AND MENTALLY RETARDED CLIENTS

Clients	Accepts Treatment	Refuses Treatment	Emergency Situation	
Competent Capable in fact and/or Adjudicated Competent	Treat	Do not treat	Do not treat	Follow Restraint Regulations (See VB)
Not Capable in Fact	Continue to treat Follow procedures for court action (See VB)	Do not treat Follow procedures for court action (See VA)	Treat on interim basis only (See VC)	Follow Restraint Regulations (See VB)
Adjudicated Incompetent With substituted judgement treatment decision	Carry out substituted judgement treatment decision	Carry out substituted judgement treatment decision	Treat on interim basis only (See VC)	Follow Restraint Regulations (See VB)
Adjudicated Incompetent Without substituted judgement treatment	Continue to treat Follow procedures for court action (See VIA)	Do not treat Follow procedures for court action (See VA)	Treat on interim basis only (See VC)	Follow Restraint Regulations (See VB)

* References in this chart to numbered paragraphs (e.g., “See VA”, or “See VB” are intended to refer to the discussion contained in the attached Ames-Callahan legal memorandum dated 12/16/93.